ALABAMA BOARD OF EXAMINERS FOR
SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY
P.O. Box 304760 Montgomery, Alabama 36130-4760
Telephone Number: 334-269-1434 Fax Number: 334-834-9618

# SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY ASSISTANT REGISTRATION

NOTE: **Type or print clearly.** There is a $100.00 application fee charged for each Assistant registration. The fee must be enclosed with application.

## ASSISTANT INFORMATION

Name of Assistant_____

Home Phone:_____Social Security Number:_____

Home Address: _____
Street

_____
City State Zip

Email:_____

Applying for assistant authorization in: ( ) Audiology ( ) Speech Pathology

U.S. Citizen: __YES ___N0 Legal Alien: ___YES ___No Visa Type & Number_____

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## CITIZENSHIP/IMMIGRATION STATUS
### (THIS SECTION MUST BE COMPLETED BY ASSISTANT)

Per Code of Alabama 1975, §31-13-5 of the Beason-Hammon Alabama Taxpayer and Citizen Protection Act -Immigration Law, all persons holding or applying for a license/registration to practice in Alabama must show proof of citizenship or immigration status.

Please check appropriate status, and return your **documentation** along with your licensure application.

**_____ I am a United States Citizen. I am submitting the attached copy of my document to prove citizenship/legal presence:**
_____ Alabama Driver's License or Identification issued by Department of Public Safety
_____ Driver's License from other state that required proof of lawful presence
_____ Birth Certificate indicating US birth
_____ Valid US Passport
_____ Military Identification showing US as place of birth
_____ Naturalization documents
_____ Certificate of citizenship
_____ Consular report of birth abroad of US citizen
_____ Bureau of Indian Affairs identification
_____ American Indian Card issued by Homeland Security

_____ Final adoption decree showing person's name and place of US birth
_____ A valid Uniformed Services Privileges and Identification Card
_____ Extract from a United States hospital record of birth created at the time of the person's birth indicating the place of birth in the United States
_____ Certification of birth issued by U S Department of State
**_____ I am not a United States Citizen. The copy of the document(s) to prove legal presence I am submitting (and attached to this checklist) is as follows:**
_____ I-327 Re-entry Permit
_____ I-551 Permanent Resident Card
_____ I-571 Refugee Travel Document
_____ I-766 Employment Authorization Card
_____ I-94 Arrival/Departure Record
_____ Unexpired Foreign Passport
_____ Temporary I-551 Stamp (on passport or I-94)
_____ I-20 Certificate of Eligibility for non-immigrant (F-1) student status
_____ DS 2019 Certificate of Eligibility for Exchange Visitor (J-1) status
_____ Machine-readable immigrant Visa (with temporary I-551 language)
_____ Other: (Explain)

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**This session must be completed by the supervising speech-language pathologist or audiologist**

## Supervisor Information:

Name of Supervisor:_____ABESPA Lic. No._____

Date of Application:_____ Type of License: SLP_____ AUD_____

Mailing Address: _____
Street

_____
City State Zip

Home Phone:_____ Work Phone:_____

Provide the name(s) of other assistants working under your supervision and the **number of hours per week** worked by each:

(1) _____

(2) _____

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A SUPERVISOR'S RESPONSIBILITIES INCLUDE BUT ARE NOT LIMITED TO:

1. Assessing patients, making diagnoses, and establishing treatment procedures.
2. Counseling patients and/or family members regarding diagnosis and/or treatment.
3. Re-evaluating patients on a timely basis and evaluating on-going appropriateness and effectiveness of management plan.
4. Being onsite at all times while the assistant is providing clinical services and documenting direct observation of at least 10% of all clinical services provided by the assistant.
5. Ensuring that the Assistant **does not** start employment until application is approved by the ABESPA Board.
6. Supervising not more than two full-time Assistants (full-time is 30 hours or more per week)
7. Notifying ABESPA when she/he terminates supervision of Assistant.
8. Ensuring that ten (10) clock hours of continuing education have been completed by renewal date.

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**WORK PLAN FOR THE ASSISTANT** (Attach additional sheets if needed)

1. Place(s) of employment as an Assistant:

_____

Institution Name

_____

Address (including city, state and zip code)

_____

Telephone Number

2. Number of hours the Assistant will work per week: _____

3. Description of the activities to be performed by the Assistant: _____

_____

_____

_____

4. Description of training the Assistant has received in the past in order to prepare for the performance of the planned activities:_____

_____

_____

_____

Assistant's Education Background: (transcripts must be forwarded to the Board)

| Institution | City | State | From | To | Degree |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

5. Describe the amount and type of training to be provided by the Supervisor to prepare the Assistant to perform the proposed plan:_____

_____

_____

_____

_____

_____

We hereby certify that all information pertaining to this application is true and correct and that the Alabama Board of Examiners for Speech-Language Pathology and Audiology is hereby granted permission to obtain verification of education and employment dates reported herein as well as verification of any other information regarding specific duties and supervision provided. **We understand that the supervision licensee assumes all professional responsibility and liability for any actions performed by the Assistant while the Assistant is working under this authorization**. We agree that, while providing clinical services, an assistant will wear a badge identifying assistant status. We have read and understand the rules and regulations governing Assistant Authorization. We understand that should the undersigned licensee cease to supervise the Assistant, the Assistant's registration is automatically terminated. To receive Assistant status after termination by Supervisor, the Assistant must reapply. We understand that this Assistant Authorization expires on December 31 and must be renewed.

_____

Signature of Licensee/Supervisor Date

_____

Signature of Assistant Applicant Date

**SWORN** to and **SUBSCRIBED** before me on this the _____ day of _____, 20_____.

_____

Notary Public
My Commission Expires:_____

**ABESPA does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.**